471-000-201 Example of Form MC-9D "Dental Treatment and Prior Authorization"

USE: Form MC-9D is completed by the Medicaid Division and used to prior authorize payment for dental services as required in 471 NAC 6-000.

COMPLETION: Form MC-9D is completed only if the client is/was Medicaid eligible for the period for which payment for services are being authorized. **The authorization becomes invalid if the client becomes ineligible for Medicaid benefits.**

Form MC-9D is completed only if the provider is/was enrolled in the Nebraska Medical Assistance Program during the period for which payment is being authorized. The authorization becomes invalid if the provider is suspended or terminated from the program.

1. CLIENT CASE NUMBER: The client's 11-digit Medicaid case number is entered in this field. If authorizing pregnancy-related services for an ineligible mother of an eligible unborn child, enter the Medicaid number of the unborn child.

   CLIENT NAME: The client's name is entered. If authorizing pregnancy-related services for an ineligible mother of an eligible unborn child, enter the name of the mother. Providers shall verify that the authorization is for the correct client before providing treatment.

2. MEDICAID PROVIDER NUMBER: The provider's 11-digit Medicaid provider number is entered in this field. Verify that the provider number is correct.

   PROVIDER NAME: The provider name is entered.

   DATE RECEIVED: The date the prior authorization request was received in the Medicaid Division is entered.

3. CODE, TOOTH NO., NO. OF SVS., DESCRIPTION OF SERVICE, AMOUNT:

   CODE: The procedure code of the service(s) being authorized is entered. If a procedure code listed is different than the requested treatment on the ADA form review section 6 for consultant comments.

   TOOTH NO.: If the treatment prior authorized is tooth specific the tooth number is entered in this field.

   NO. OF SVS.: The number of times the procedure code is prior authorized is entered. Most procedures will be "1".

   DESCRIPTION OF SERVICE: Complete when a miscellaneous code is authorized.

   AMOUNT: Complete if the procedure code prior authorized is listed as "BR" (by report.) This field is left blank if the procedure has an established fee on the Medicaid Dental Fee Schedule.

   A maximum of five codes can be authorized on one form. If additional codes in the treatment plan require prior authorization an additional form is completed. Not all codes listed on the pre-treatment ADA form will be authorized on the MC-9D. Only those services that require prior authorization are listed on Form MC-9D.

4. Treatment plan as submitted has been denied as (1 – 6):

   The dental consultants will check appropriate statements regarding why treatment was denied. Field 4. (1) is checked if the treatment can not be authorized because the client's Medicaid eligibility has closed. The date Medicaid eligibility closed is entered.

5. Treatment has been approved (7 and 8):

   The dental consultants will check this statement when treatment has been approved. If requesting post-operative x-rays of a completed root canal the consultants will check 5. (7). The x-rays shall be sent with the ADA claim when submitting for payment. If 5. (7) is not checked DO NOT send the post-operative x-ray when submitting for payment.

   Field 5. (8) is checked if the client's Medicaid eligibility is closing. The date Medicaid eligibility is ending is entered.

6. DELETIONS, SUBSTITUTIONS, ADDITIONS:

   The consultants will list the deletion of services, substitutions of services, or addition of services in this section. Provider should review this section before providing treatment.

   If the Department dental consultants make treatment substitutions the treating dentist shall correct the procedure code on the ADA claim form when submitting for payment.

7. SIGNATURE OF AUTHORIZED AGENT, DATE:

   The Department dental consultant or authorizing agent signs and dates the MC-9D.

To view printable form click here: Dental Treatment and Prior Authorization

DENTAL TREATMENT AND PRIOR AUTHORIZATION

Nebraska Health and Human Services System
Medicaid Division

"This Authorization is Void if Client is Ineligible"

[I] Dental

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM

1. Client Case Number	2. Medicaid Provider Number
Client Name	Provider Name
Client Birthdate Month / Day / Year	Date Received

3.	CODE	TOOTH NO.	NO. OF SVS.	DESCRIPTION OF SERVICE	AMOUNT
(1)					
(2)					
(3)					
(4)					
(5)					

4. _____ Treatment plan as submitted has been denied as:
   - (1) _____ Client's Medicaid eligibility closed _____.
   - (2) _____ Inadequate information to evaluate the requested treatment.
   - (3) _____ Treatment requested is not an allowed service by program policy.
   - (4) _____ Adequate occlusion by program policy does not qualify for a partial.
   - (5) _____ Prosthetic appliance not allowed by program policy.
   - (6) _____ Client does not have a handicapping malocclusion as defined in program policy.

5. _____ Treatment has been approved:
   - (7) _____ Send a postoperative radiogram of the completed endodontic treatment with the ADA form when submitting for payment.
   - (8) _____ Client's Medicaid eligibility is closing _____. Medicaid can not pay for treatment after that date.

6. Deletions:

Substitutions:

Additions:

7. I certify that the listed goods or services are authorized under the rules and regulations of the Nebraska Department of Health and Human Services.

Medicaid Division	Signature of Authorized Agent	Date

MC-9D Rev. 11/01 (01012)
(Previous version 2/98 should be used first)